HIE Steering Committee

Claims Pilot Subcommittee

Meeting #8 - July 30, 2021

Agenda

- Review New Use Cases: Quality Improvement and Reporting for Medicaid and the Blueprint
- Next Steps

Role of Subcommittee Members Re: Use Cases

- Learn about each of the use cases presented by fellow subcommittee members
  - *What is the user trying to accomplish? How does this relate to or inform my use cases?*
- Weigh in: support editing, culling, prioritizing
  - *How could this be augmented to be clearer? Is it missing anything? Where does this fit in your sense of priorities?*
- Support assessment of technical feasibility by VITL and MMIS partners

Use Case Categories - Definition

- Clinical uses – Individual:
  - These use cases focus **on how data/information is used in a clinical setting to support clinical decisions** made **between an individual and their provider**.

- QI/operational - Organization:
  - These use cases focus **on how data is used by an organization** and can be grouped into two categories. 1) How a health care organization uses data **to improve its processes/workflow** and improve panel management for groups of patients. 2) How a program uses data **to enhance operations** such as setting payment levels for value-based payments or making policy decisions on how the program operates.

- Evaluation – Population health:
  - These use cases focus on whether a program, policy, or intervention achieved what it meant to achieve. The **outcomes are used to support decision making**; can be more dynamic and flexible that reporting, though often rely on similar nationally recognized measures; see below.

- Reporting – Population Health:
  - These use cases are **measures** often agreed upon at the beginning of a program/ agreement/demonstration **to be monitored by an overseeing entity**, e.g., the federal government. Generally, these **measures are drawn from nationally recognized measures**.

Use Case Review

USE CASE: QI/Operations - Organization

Medicaid Program Integrity

USER STORY

Actor(s): Financial Director at Department of Vermont Health Access (DVHA), Data SME, Program Integrity Unit, Medicaid Providers, MFRAU (), Departmental Program Managers/Leads

As an Analyst for the Program Integrity Unit, I need data to identify and assess possible fraud or abuse by providers in billing the Vermont Medicaid program. Fraud and abuse are both defined in Medicaid regulations (42 CFR 433.304 and 42 CFR 455.2). Fraud involves an intentional deception, such as billing for services that were never provided. Abuse includes taking advantage of loopholes or bending the rules, such as improper billing practices.

The goal is to ensure the Medicaid program and by extension, Vermont taxpayers are not paying for these deceptive activities. By reviewing both Claims and Clinical Data linked at the encounter level, I can assess whether services recorded in the Clinical record correspond to services billed, and appropriately so, to Medicaid.

An algorithm could be developed to look across both the Clinical record and the filed Claims to find incidents of upcoding or non-delivered but billed services.

Access to linked Claims and Clinical Data would remove the need for manual chart reviews, which is the current approach to verify services billed are also in the Clinical record or Clinically necessary.

DVHA would prefer to prioritize the data attributes of the clinical records based on the probability of fraud, waste, and abuse based on service type delivery.

ORGANIZATIONS

1. DVHA/AHS is the Medicaid Payer in the Provider-Payer relationship system.
2. Yes, DVHA consumes the Claims data from Provider, adjudicates the Claims, and produce the final Claim data in Provider-Payer relationship system.
3. Yes, DVHA uses the Claims data for Federal and State use Reporting and Analytics, Claims assessment for payments to Payers

CHALLENGES/PAIN POINTS

1. Access:

a. Yes, DVHA has access to Clinical Data. Providers send manual chart reviews to DVHA on request from DVHA.

b. Yes, DVHA has access to Claims Data.

c. No.

2. Challenges/pain points:

a. Improve DVHA's ability to identify fraud and abuse.

b. Eliminate the need to do manual chart reviews e.g. tracking health care outcomes at individual and population level.

c. Timely availability of linked Clinical and Claims information from Providers

GOAL

DVHA's goal is to identify fraud and abuse of the Medicaid program and eliminate it more efficiently.

USE CASE: QI/Operations - Organization

Medicaid Program Integrity

TRADING PARTNERS AND SYSTEMS

1. **Systems**:
   a. SoV Data Warehouse - MSRs (Monthly Service Reports): Used by Dept. of Mental Health and DAIL (Disabilities, Aging and Independent Living)
   b. SoV Data Warehouse - MMIS EVAH (Enhanced Vermont Ad-Hoc??)
   c. MMIS AIM (Claims Processing System)
   d. Business Objects

2. **Partners**:
   a. Medicaid Providers
   b. Pharmacy
   c. Gainwell Technologies
   d. Change Health Care

DATA TO EXCHANGE

1. Various Electronic Health Record (EHR) from Providers
2. Medical Charts from Providers
3. Case Records
4. Actual paper Claims from Providers
5. Death Records and Vital Statistics
6. Monthly Service Reports (MSRs)

DATA GOVERNANCE

1. HIPAA
2. 42 CFR Part 2
3. Medicaid Regulations (42 CFR 433.304 and 42 CFR 455.2)

FREQUENCY

At a minimum Weekly, but no greater than Monthly

USE CASE TARGET DATE

When the linked Clinical and Claims Data is available at VHIE.

Yes, DVHA gets the Clinical data today, through manual intervention.

MMIS DATA PIPELINE

DVHA will need the adjudicated (paid/denied) Claims Data, which is at the end of the pipeline.

DATA FORMAT (Source to VHIE)

TBD with Technical Team

TRANSPORT MECHANISM

TBD, but ideally planning to do everything in APIs

DATA RECIPIENT FORMAT (VHIE to End User)

TBD with technical team

CONSENT SPECIFICATIONS

As a Medicaid authority for the State, DVHA has access to Claims Data. So, patient consent is not required.

LEGAL AGREEMENTS

Data Sharing agreements needs to be defined and agreed about how much of Medicaid (identifiable) Data can be shared by VHIE to other Payers/Users (e.g., BCBS)

USE CASE: Evaluation - Population

Utilization Management

USER STORY

Actor(s): Financial Director at Department of Vermont Health Access (DVHA), Data SME, Program Integrity Unit, Medicaid Providers, MFRAU (), Departmental Program Managers/Leads

As a Data SME for the Program Integrity Unit, **I need to** use the linked Clinical and Claims Data, **So that** I can perform data mining to identify wasteful or inappropriate utilization of services and misuse of resources. Reviewing utilization of services that fall into these categories has two benefits: 1) Improving patient care by continually assessing whether a patient is receiving the right care for their needs; and 2) avoiding unnecessary costs of duplicative or unneeded care to the Medicaid program.

Waste, which is not defined in federal Medicaid regulations, includes inappropriate utilization of services and misuse of resources. An example would be the duplication of tests that can occur when providers do not share information with each other. Waste is not a criminal or intentional act but results in unnecessary expenditures to the Medicaid program that might be prevented.

Utilization Management(UM) is a set of techniques used by or on behalf of health care benefits purchasers to manage health care costs. These methods include supporting patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision.

- High-Cost Case management (also called large case management), Medical Case management, Catastrophic Case management, or Individual Benefits management focuses on the relatively few beneficiaries in any group who are likely to generate very high expenditures.
- Linked Clinical and Claims data can provide insight into utilization patterns, health status, and health outcomes to support decisions around, triaging, referrals to specialists, and use of medical devices in order to manage patient flow and use of expensive services. These insights can also support physician education and feedback on standards of care.
- Algorithms can be developed and used to determine if the Clinical Data corresponded to the billed Claims data, which would find and isolate duplicative services in encounter Claims and identify incidents of waste in which Providers are performing duplicative testing due often due to isolation of testing and lab data.
- DVHA is looking for linked Clinical and Claims Data at an encounter level in VHIE.
- DVHA would prefer to prioritize the data attributes of the clinical records based on the probability of fraud, waste, and abuse based on service type delivery.

USE CASE: Evaluation - Population

Utilization Management

ORGANIZATIONS

1. DVHA/AHS is the Medicaid Payer in the Provider-Payer relationship system.
2. Yes, DVHA consumes the Claims data from Provider, adjudicates the Claims, and produce the final Claim data in Provider-Payer relationship system.
3. Yes, DVHA uses the Claims data for Federal and State use Reporting and Analytics, Claims assessment for payments to Payers

CHALLENGES/PAIN POINTS

1. Access:
   a. No, the State's access to clinical data for this purpose is currently inadequate in terms of content scope, sample sizes, time coverage, data quality, and timeliness.
   b. Yes, the State has access to claims data in the Medicaid claims data warehouse (EVHA) and in the all-payer claims dataset (VHCURES).
   c. No, the State's access to integrated clinical and claims data for this purpose is currently inadequate, primarily due to a lack of adequate clinical data extracts for linkage.
2. Challenges/pain points:
   a. Improve DVHA's ability to identify fraud and abuse.
   b. Eliminate the need to do manual chart reviews e.g. tracking health care outcomes at individual and population level.
   c. Timely availability of linked Clinical and Claims information from Providers

GOAL

DVHA's goal is to identify inappropriate utilization of services and misuse of resources in the Medicaid program and eliminate waste and improve quality of services more efficiently.

TRADING PARTNERS AND SYSTEMS

1. Systems:
   a. SoV Data Warehouse - MSRs (Monthly Service Reports): Used by Dept. of Mental Health and DAIL (Disabilities, Aging and Independent Living)
   b. SoV Data Warehouse - MMIS EVAH (Enhanced Vermont Ad-Hoc??)
   c. MMIS AIM (Claims Processing System)
   d. Business Objects
2. Partners:
   a. Medicaid Providers
   b. Pharmacy
   c. Gainwell Technologies
   d. Change Health Care

DATA TO EXCHANGE

1. Various Electronic Health Record (EHR) from Providers
2. Medical Charts from Providers
3. Case Records
4. Actual paper Claims from Providers
5. Death Records and Vital Statistics
6. Monthly Service Reports (MSRs)

DATA GOVERNANCE

1. HIPAA
2. 42 CFR Part 2

FREQUENCY

At a minimum Weekly, but no greater than Monthly

USE CASE TARGET DATE

When the linked Clinical and Claims Data is available at VHIE.
Yes, DVHA gets the Clinical data today, through manual intervention.

MMIS DATA PIPELINE

DVHA will need the adjudicated (paid/denied) Claims Data, which is at the end of the pipeline.

DATA FORMAT (Source to VHIE)

TBD with Technical Team

TRANSPORT MECHANISM

TBD, but ideally planning to do everything in APIs

DATA RECIPIENT FORMAT (VHIE to End User)

TBD with technical team

CONSENT SPECIFICATIONS

As a Medicaid authority for the State, DVHA has access to Claims Data. So, patient consent is not required.

LEGAL AGREEMENTS

Data Sharing agreements needs to be defined and agreed about how much of Medicaid (identifiable) Data can be shared by VHIE to other Payers/Users (e.g., BCBS)

USE CASE: Evaluation - Population

Benefit Design

USER STORY

Actor(s): Financial Director at Department of Vermont Health Access (DVHA), Data SME, Departmental Program Managers/Leads

As a Policy Leader with decisions over adding, removing, or modifying Medicaid Plan benefits, I need data that can be used to evaluate the scope of the problem that would be addressed through changes to benefits, project the impact of making a change to a benefit, and monitoring the impact of the benefit change. While Claims alone can assess current utilization patterns around the benefit in question, such as coverage in dental care or chronic pain management, linked Claims and Clinical data can provide insight into health status and Clinical outcomes. For example, when considering management of chronic pain services and what is covered under Medicaid, analysis of Claims and Clinical data would describe the types of services provided, the frequency of services, cost of services, and indications of health outcomes from services. Projections for the impact of changing the types of services covered and how they are paid for could be estimated. Then, Claims and Clinical data could be used to assess whether the changes in benefits covered had an impact on utilization patterns or Clinical outcomes.

DVHA defines patient cost-sharing and coverage exclusions, consumer education, and other approaches that shape patient demand for care. This activity is done primarily through Claim data today but there could be benefit in reviewing the Clinical data in the future.

DVHA is looking for linked Clinical and Claims Data at an encounter level in VHIE.

USE CASE: Evaluation - Population

Benefit Design

ORGANIZATIONS

1. DVHA/AHS is the Medicaid Payer in the System.
2. Yes, consume the claims from Provider, adjudicate and produce final claims data in Provider-Payer relationship
3. Yes, use it for federal and state use reporting and analytics, assess for payments to Payers

CHALLENGES/PAIN POINTS

1. Access:
   a. No, the State's access to clinical data for this purpose is currently inadequate in terms of content scope, sample sizes, time coverage, data quality, and timeliness.
   b. Yes, the State has access to claims data in the Medicaid claims data warehouse (EVHA) and in the all-payer claims dataset (VHCURES).
   c. No, the State's access to integrated clinical and claims data for this purpose is currently inadequate, primarily due to a lack of adequate clinical data extracts for linkage.
2. Challenges/pain points:
   a. Limits the ability to do financial modelling.
   b. Longitudinal data points to assess the impact of benefit design change

GOAL

DVHA's goal is to define, assess and make appropriate modifications to Medicaid benefits, including patient cost-sharing, and covered services, consumer education, and other approaches that shape how patients access care, improve outcomes, and contain expenditures.

TRADING PARTNERS AND SYSTEMS

1. Systems:
   a. SoV Data Warehouse - MSRs (Monthly Service Reports): Used by Dept. of Mental Health and DAIL (Disabilities, Aging and Independent Living)
   b. SoV Data Warehouse - MMIS EVAH (Enhanced Vermont Ad-Hoc??)
   c. MMIS AIM (Claims Processing System)
   d. Business Objects
2. Partners:
   a. Medicaid Providers
   b. Pharmacy
   c. Gainwell Technologies
   d. Change Health Care

DATA TO EXCHANGE

1. Various Electronic Health Record (EHR) from Providers
2. Medical Charts from Providers
3. Case Records
4. Actual paper Claims from Providers
5. Death Records and Vital Statistics
6. Monthly Service Reports (MSRs)

DATA GOVERNANCE

1. HIPAA
2. 42 CFR Part 2

FREQUENCY

At a minimum Weekly, but no greater than Monthly

USE CASE TARGET DATE

When the linked Clinical and Claims Data is available at VHIE.
Yes, DVHA gets the Clinical data today, through manual intervention.

MMIS DATA PIPELINE

DVHA will need the adjudicated (paid/denied) Claims Data, which is at the end of the pipeline.

DATA FORMAT (Source to VHIE)

TBD with Technical Team

TRANSPORT MECHANISM

TBD, but ideally planning to do everything in APIs

DATA RECIPIENT FORMAT (VHIE to End User)

TBD with technical team

CONSENT SPECIFICATIONS

As a Medicaid authority for the State, DVHA has access to Claims Data. So, patient consent is not required.

LEGAL AGREEMENTS

Data Sharing agreements needs to be defined and agreed about how much of Medicaid (identifiable) Data can be shared by VHIE to other Payers/Users (e.g., BCBS)

USE CASE: Evaluation - Population

Cost of Care (Moving away from payments based on fee-for-service [FFS] to value-based payments [VBP])

USER STORY

Actor(s): Financial Director at Department of Vermont Health Access (DVHA)

As a Medicaid Administrator, I am looking for accurate cost of care estimates for Medicaid enrollees in order to make decisions around alternative payment models. To date, cost of care estimates and benchmarks have been made through retrospective analysis of fee-for-service claims. However, as more payments shift to prospective capitated payments, and fewer services are covered solely by fee-for-service, these claims become less valuable as an indicator of actual costs of care. Therefore, I would seek to work with actuaries to determine what data and the data sources, including clinical records, will be most valuable to establish cost of care benchmarks moving forward. For example, will the clinical record in conjunction with encounter claims data provide a more complete summary of services provided, patient health status, and changes in utilization patterns over time? And could this information be used to adjust and update expenditure benchmarks in a way that supports cost containment strategies, health service payment and delivery reform, and improved quality of care while ensuring appropriate compensation of providers?

GOAL

To improve methods for calculating utilization, quality, total cost of care, other expenditure measures, and benchmarks in each of those areas. It is possible that claims submissions will become less detailed and comprehensive with the shift from FFS payments to VBP, which will increase the need for more timely, comprehensive, and accessible clinical information.

USE CASE: Evaluation - Population

Cost of Care (Moving away from payments based on fee-for-service [FFS] to value-based payments [VBP])

ORGANIZATIONS

1. DVHA/AHS is the Medicaid payer in the provider-payer relationship.
2. Yes, DVHA consumes claims data from providers, adjudicates the claims, and produces the final claims data.
3. Yes, DVHA uses the claims data for Federal and State reporting and analytics (including utilization, cost, and quality reporting), and uses adjudicated claims to make payments to providers.

CHALLENGES/PAIN POINTS

1. Access:
   a. No, the State's access to clinical data for this purpose is currently inadequate in terms of content scope, sample sizes, time coverage, data quality, and timeliness.
   b. Yes, the State has access to claims data in the Medicaid claims data warehouse (EVHA) and in the all-payer claims dataset (VHCURES).
   c. No, the State's access to integrated clinical and claims data for this purpose is currently inadequate, primarily due to a lack of adequate clinical data extracts for linkage.
2. Challenges/pain points:
   a. Improve DVHA's ability to identify fraud and abuse.
   b. Eliminate the need to do manual chart reviews (e.g., tracking health care outcomes at individual and population levels).
   c. Timely availability of linked clinical and claims information from providers.

TRADING PARTNERS AND SYSTEMS

1. Systems:
   a. SoV Data Warehouse - MSRs (Monthly Service Reports): Used by Dept. of Mental Health and DAIL (Disabilities, Aging and Independent Living)
   b. SoV Data Warehouse - MMIS EVAH (Enhanced Vermont Ad-Hoc??)
   c. MMIS AIM (Claims Processing System)
   d. Business Objects
2. Partners:
   a. Medicaid Providers
   b. Pharmacy
   c. Gainwell Technologies
   d. Change Health Care

DATA TO EXCHANGE

1. Various Electronic Health Record (EHR) from Providers
2. Medical Charts from Providers
3. Case Records
4. Actual paper Claims from Providers
5. Death Records and Vital Statistics
6. Monthly Service Reports (MSRs)

DATA GOVERNANCE

1. HIPAA
2. 42 CFR Part 2

FREQUENCY

At a minimum Weekly, but no greater than Monthly

USE CASE TARGET DATE

When the linked Clinical and Claims Data is available at VHIE.
Yes, DVHA gets the Clinical data today, through manual intervention.

MMIS DATA PIPELINE

DVHA will need the adjudicated (paid/denied) Claims Data, which is at the end of the pipeline.

DATA FORMAT (Source to VHIE)

TBD with Technical Team

TRANSPORT MECHANISM

TBD, but ideally planning to do everything in APIs

DATA RECIPIENT FORMAT (VHIE to End User)

TBD with technical team

CONSENT SPECIFICATIONS

As a Medicaid authority for the State, DVHA has access to Claims Data. So, patient consent is not required.

LEGAL AGREEMENTS

Data Sharing agreements needs to be defined and agreed about how much of Medicaid (identifiable) Data can be shared by VHIE to other Payers/Users (e.g., BCBSVT)

Hybrid Performance Measure Production - Examples: Controlling High Blood Pressure and Diabetes in Poor Control

USER STORY

Actors: DVHA Quality and Data Analysts, Federal Oversight Bodies e.g., CMS

As an Analyst for the State, I am responsible for reporting to federal oversight bodies results for agreed upon measures. Two priority measures include controlling high blood pressure, which assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg, NQF 0018); and assessing those with diabetes in poor control (percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period, NQF 0059). Both measures require both clinical and claims data to produce an outcome, and the ability to automatically integrate this data without having to do chart reviews would be beneficial to both analysts, who would have access to a broader sampling on the patient population, and the practices who then would not need to work with analysts to conduct chart reviews.

As an Analyst for the State,

I want to be able to access and use the aggregated Claims and Clinical Data,

So that I can report to federal oversight bodies the results for agreed upon measures i.e., 'Percent of population with hypertension in control' and 'Diabetes in Poor Control'

GOAL

To improve methods for calculating hybrid performance measures (such as Controlling High Blood Pressure and Diabetes Poor Control) for the Vermont Medicaid population.

USE CASE: Evaluation - Population

Hybrid Performance Measure Production - Examples: Controlling High Blood Pressure and Diabetes in Poor Control

ORGANIZATIONS

1. DVHA - manages Vermont's Medicaid Program
2. Yes, DVHA consumes claims data from providers, adjudicates the claims, and produces the final claims data.
3. Yes, DVHA uses the claims data for Federal and State reporting and analytics (including utilization, cost, and quality reporting), and uses adjudicated claims to make payments to providers.

CHALLENGES/PAIN POINTS

1. Access:

a. No, the State's access to clinical data for this purpose is currently inadequate in terms of content scope, sample sizes, time coverage, data quality, and timeliness.

b. Yes, the State has access to claims data in the Medicaid claims data warehouse (EVHA) and in the all-payer claims dataset (VHCURES).

c. No, the State's access to integrated clinical and claims data for this purpose is currently inadequate, primarily due to a lack of adequate clinical data extracts for linkage.

2. Challenges/pain points:

a. Eliminate the need to do manual chart reviews.

b. Timely availability of linked clinical and claims information from providers.

DATA TO EXCHANGE

1. Past and current clinical data: e.g., blood pressure readings from clinical settings, recorded in EMRs.
2. Past and current claims data: e.g., diagnoses, procedures, and health service utilizations

TRADING PARTNERS AND SYSTEMS

1. Systems:
   a) Claims data - MMIS
   b) Clinical data - from VHIE
2. Partners:
   a) Providers
   b) VITL
   c) Gainwell
   d) Change Healthcare.

DATA GOVERNANCE

1. HIPAA
2. Data provided as limited dataset OR deidentified data (does VHIE consent policy apply? Question to VITL Legal Rep)

USE CASE TARGET DATE

Target: When the linked clinical and claims Data is tested and available at VHIE.

Yes, DVHA gets certain hybrid performance measure clinical data today, through manual chart abstraction for a sample of the Medicaid primary population (via DVHA clinicians using an NCQA-certified vendor's data collection software) and through OneCare VT reporting (aggregate) for the VMNG ACO population (also obtained through manual chart abstraction).

FREQUENCY

At a minimum, annually. Ideally, quarterly.

MMIS DATA PIPELINE

TBD with Technical Team

DATA FORMAT (Source to VHIE)

Readable in my EHR OR available to my Practice, Preferably in FHIR.

TRANSPORT MECHANISM

Data Extract or API(Preferably in FHIR).

DATA RECIPIENT FORMAT (VHIE to End User)

TBD with technical team

CONSENT SPECIFICATIONS

No

LEGAL AGREEMENTS

Providers' enrollment agreements with DVHA allow for us to request and use the data.

Group Discussion

Use Case Gathering Sessions

#	Interview	Focus of Discussion	Schedule & Status
1	**Katie Muir**, *OneCare VT*	• Evaluation & Reporting of the APM • Support of clinical practices and the care model	**3/3/2021 – Completed**
2	**Pat Jones**, *DVHA Payment Reform* **Erin Flynn**, *DVHA Payment Reform*	• Evaluation & Reporting of the APM • Support of clinical practices and the care model	**3/30/2021 – Completed**
3	**Ben Green**, *Blue Cross Blue Shield* **James Mauro**, *Blue Cross Blue Shield*	• Commercial Claims	**4/19/2021 – Completed**

4	**Sarah Lindberg**, *Green Mountain Care Board*	• Analytics for -
		  • evaluating the APM
		  • evaluating the Boards regulatory activities
			5/10/2021 – Completed

5	**Thomasena E Coates**, *Blueprint QI Facilitator* **Lauri Scharf**, *BiState Primary Care Assoc.*	• Point of care support	**6/1/2021 – Completed** **6/22/2021 – Completed**
6	**Lisa Schilling**, *Medicaid Operation* **Erin Carmichael**, *Medicaid Quality* **Shawn Skaflestad**, *Medicaid Performance Management/Improvement* **Tim Tremblay**, *Vermont Blueprint for Health*	• Quality Improvement and Reporting for Medicaid and the Blueprint • Overall evaluation of GC1115 waiver	**6/10/2021 – Completed**

Brainstorming: What's Next?

Use Case Category	Outstanding Questions	Accountable for Outcome	Next Steps
Clinical Uses – Individual	Do we understand if/how claims data can enhance care delivery? Which health care representatives can help VITL determine how this person-level data should be presented/made available?	*New Clinical Subcommittee?*	*Recommend to Steering Committee that Clinical Subcommittee help answer these questions?*
QI/operational - Organization	Are there potential users of VHIE-sourced data to support QI/practice improvement that we haven't considered? How do we engage these potential users in designing data solutions to meet their operational needs?	*New Clinical Subcommittee?*	*Recommend to Steering Committee that Clinical Subcommittee help answer these questions?*
Evaluation – Population health	Is there a need for a publicly available de-identified data set for commonly used evaluation measures (e.g., diabetes, depression screening)?	*Steering Committee?*	
Reporting – Population Health	Can VITL use clinical and claims data to automate standard reporting for payers (e.g., HEDIS)? Are providers comfortable with this type of automation?	*Individual VITL customers?*	

Use Cases Summary

	Category	Use Case Name	Stakeholder
1	Clinical - Individual	Prescription Reconciliation, Fulfillment Monitoring	Mary Kate Mohlman
2	Clinical - Individual	Validate the Service Provided	Mary Kate Mohlman
3	QI/Operations - Organization	Panel Management of Individuals with Chronic Conditions– identifying those whose conditions need better management	Mary Kate Mohlman
4	Evaluation - Population	Assessing Quality Improvement Initiatives on Hypertension Control and Outcomes	Mary Kate Mohlman
5	Reporting - Population	Percent of population with Hypertension in control and Diabetes in poor control	Mary Kate Mohlman
6	QI/Operations - Organization	Improving support and Care management for individuals with Hypertension and Diabetes in the State	Katelyn Muir
7	QI/Operations - Organization	Improve Immunization Rate	Katelyn Muir
8	Evaluation - Population	Evaluating the Clinical impact of the Care Coordination Model	Katelyn Muir
9	Evaluation - Population	Evaluation of primary prevention by Health Service Areas (HSA)	Katelyn Muir
10	QI/Operations – Organization	Determine payments made to providers participating in Medicaid value-based payment arrangements.	Pat Jones Erin Flynn
11	Reporting - Population	AHS/DVHA Payment Reform Alternative Payment Model Program Monitoring and Reporting	Pat Jones Erin Flynn

Use Cases Summary

	Category	Use Case Name	Stakeholder
12	Clinical – Individual	Help inform Care Management Functions	James Mauro
13	QI/Operations – Organization	Identify Members for Integrated Health Programming including Risk Stratification	James Mauro
14	Evaluation - Population	Evaluate the performance of a Healthcare Reform/Payment Reform Program	James Mauro
15	QI/Operations – Organization	Development of a Healthcare Reform/Payment Reform Program	James Mauro
16	Reporting - Population	Conduct quality reporting that requires clinical data without relying on manual medical chart extractions	James Mauro
17	QI/Operations – Organization	Clinical data to support Utilization Management Program	James Mauro
18	QI/Operations - Organization	Defining more precise scope of a Health Care Organization (e.g., Provider landscape)	Sarah Lindberg
19	Evaluation – Population	Evaluation of Provider Quality	Sarah Lindberg
20	QI/Operations - Organization	Quality and Equity in Health Centers in Vermont	Thomasena E Coates
21	QI/Operations - Organization	Reporting rates for preventive cancer screening (colorectal, cervical, breast) in support of improving quality of care	Lauri Scharf
22	QI/Operations - Organization	Medicaid Program Integrity	Lisa Schilling

Use Cases Summary

	Category	Use Case Name	Stakeholder
23	Evaluation - Population	Utilization Management	Lisa Schilling
24	Evaluation - Population	Benefit Design	Lisa Schilling
25	Evaluation - Population	Cost of Care (Moving away from payments based on fee-for-service [FFS] to value-based payments [VBP])	Lisa Schilling
26	Reporting - Population	Hybrid Performance Measure Production - Examples: Controlling High Blood Pressure and Diabetes in Poor Control	Erin Carmichael